LARC and PM Community of Practice

Expanding Access to Long-acting Reversible Contraceptives and Permanent Methods through Task Sharing

MEETING HIGHLIGHTS

Washington, DC
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Hosted by the LARC and PM Community of Practice Secretariat,
Population Services International (PSI), through the SIFPO2 Project

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Overview

A strong health workforce will be critical to the attainment of the goals of FP2020. Yet in many places, women and men are unable to access the contraceptive methods that suit their needs and desires, due to a shortage or inequitable distribution of family planning providers. Task sharing is the systematic delegation of tasks to a broader set of health professionals to more equitably allocate and maximize the efficient use of human resources. Task sharing strategies have the potential to optimize the skills and competencies of health workers at all levels to increase access to voluntary contraceptive services, including long-acting reversible contraceptives (LARCs) and permanent methods (PMs), within the context of informed choice.

PSI hosted a meeting with USAID and its partners, with the LARC and PM Community of Practice (CoP) to discuss current progress and future opportunities for task sharing. The agenda can be found here.

Meeting Objectives

In this meeting, the LARC and PM CoP met with the goal to learn about task sharing projects currently being done, discuss lessons learned, and think about how to develop new ways of furthering task sharing in the future. Objectives for the meeting included:

- Bring together implementers and researchers to discuss challenges in LARC and PM task sharing and identify solutions
- Explore what it will take to move task sharing from an innovation to standard practice
- Disseminate key tools for task sharing research, advocacy, and scale up

Participants

The 68 meeting participants represented USAID/Washington, USAID/Ethiopia, USAID/Nigeria, the Bill & Melinda Gates Foundation, the World Health Organization (WHO), the World Bank, the Ministry of Health of Nigeria, two academic institutions, four private industry partners (Bayer, Bioceptive, Merck, and Laerdal Global Health), and 16 cooperating agencies involved in family planning programs. The cooperating agencies included:

- EngenderHealth
- FHI 360
- Institute for Reproductive Health (IRH)
- Intrahealth
- Jhpiego
- John Snow, Inc. (JSI)
- Johns Hopkins University Center for Communication Programs (JHUCCP)
- Management Sciences for Health (MSH)
- Marie Stopes International (MSI)
- Pathfinder International
- Palladium
- Population Council
- Population Reference Bureau
- Population Services International
- PSI/Pan American Social Marketing Organization (PASMO), PSI's network member in Guatemala
- University Research Co.

Introductory remarks

Monique Burckhart, SIFPO2 Deputy Director at PSI, opened the meeting and served as the moderator.

In her introductory remarks, Kendra Phillips, Deputy Director of USAID's Office of Population and Reproductive Health, welcomed the participants and spoke about the purpose of the meeting. Ms. Phillips noted that task shifting or task sharing is included in many countries' and organizations' FP2020 commitments because it can accelerate our progress towards enabling 120 million more women and girls to use contraceptives by 2020. She highlighted how task sharing can maximize the use of health infrastructure and human resources, freeing up time for providers to serve more clients and reducing the cost of health service provision without sacrificing quality.

Ms. Phillips explained that the day would focus on the unique challenges regarding task sharing of the provision of LARCs, which include implants and intrauterine devices (IUDs), and PMs, which include vasectomy and female sterilization. Successful task sharing of LARCs and PMs requires more than just training new providers on a medical procedure. Providers need dedicated time, supplies, supervision and enough client demand to maintain competency and sustain provider skills. Ms. Phillips invited participants to use the meeting as an opportunity to share experiences, challenges and successes.

Ms. Phillips challenged participants to consider key questions, including:

- How do we avoid overloading mid-level providers and community health workers?
- How do we engage legal and regulatory structures to support task sharing?
- What are the priority research gaps, and how do we fill them?
- What can we learn from countries who have tried task sharing?
- How do we move from pilot to scale up (in terms of political will, financial and human resources)?
- How can we commit to sharing these lessons with our colleagues in the field?
- What are the next steps in carrying out the work we've already begun?

WHO Guidelines for Task Sharing of LARCs and PMs

Dr. Mario Festin, Medical Officer in the Department of Reproductive Health and Research at the WHO presented an overview of WHO guidance on task sharing. He made a clear distinction between task shifting (a term used to describe the full delegation of a task from one cadre to another) and task sharing (when providers retain responsibility for a task while a new cadre also adopts it).

Dr. Festin introduced the WHO document, "Optimizing Health Worker Roles to Improve Access to Key Maternal and Newborn and Health Interventions through Task Shifting/Sharing," which provides recommendations for the involvement of specific cadres of health providers in the delivery of services that include family planning. Due to the variability of definitions of health worker cadres across countries, the WHO has clarified cadres in this document, including the other terminologies that are commonly used in literature that refer to each cadre.

Categories for recommendations can be seen in the following table from the Optimize document:

Recommendation category	Symbol	Explanation
Recommended		The benefits of implementing this option outweigh the possible harms. This option can be implemented, including at scale.
Recommended in specific circumstances		The benefits of implementing this option outweigh the possible harms in specific circumstances. The specific circumstances are outlined for each recommendation. This option can be implemented under these specific circumstances.
Recommended in the context of rigorous research		There are important uncertainties about this option (related to benefits, harms, acceptability and feasibility) and appropriate, well designed and rigorous research is needed to address these uncertainties.
Recommended against		This option should not be implemented.

Dr. Festin described the need for policy change to allow task sharing in accordance with the WHO recommendations where it is needed. He also spoke about the need for additional, rigorous research to inform future revisions and additions to the task sharing guidelines, focusing on contraception.

The presentation ended in a game of "true or false" questions about which cadre of health worker could provide a certain type of service, according to the guidelines. Participants held up cards to represent their answers.

Lightning presentations

Elaine Menotti, Technical Advisor at the USAID Office of Population and Reproductive Health at USAID, moderated this session, which used case examples to highlight how task sharing is being used to expand LARC and PM access.

Provision of IUDs and Implants by Auxiliary Nurses in Guatemala

Dr. Leonel Gomez, Chief of Party for PSI's SIFPO2 in Guatemala, and Gynecologist and Obstetrician at PASMO spoke on work done in the rural Western Highlands of Guatemala, where there is a very low health worker density, to increase access to voluntary LARCs. Most of the country's health care providers in rural areas are not doctors or nurses, but auxiliary nurses. While auxiliary nurses are restricted by national guidelines from providing LARCs, WHO guidelines on task sharing recommend that they can insert and remove hormonal implants under specific supervisory requirements, and that their role in performing IUD insertions and removals can be considered in context of rigorous research.

Dr. Gomez explained that to test a task sharing approach, PASMO trained auxiliary nurses in family planning counseling on informed choice and WHO medical eligibility criteria, and voluntary LARC (primarily hormonal implant) provision. The project worked with 69 of the 133 facilities in the rural Western Highlands to enable more than 300 auxiliary nurses to provide these services in addition to the short-acting methods and counseling they offered before. Nurses and doctors in the same facilities remained responsible for LARC removals. As the numbers of providers who could offer LARC services grew, so did the percentage of clients choosing them.

Quality assurance visits to the health facilities showed that WHO-based quality standards for IUD and implant insertion were above 95% on average. Quality assurance audits led by PASMO and the Ministry of Health (MoH) found a balanced process of family planning counseling, including information on contraceptive effectiveness, and informed and voluntary decision-making by clients.

As a result of these successes, MoH has agreed to include voluntary LARC provision by auxiliary nurses in the 2017 update to the national family planning guidelines, and include training on LARC provision in the pre-service curriculum for auxiliary nurses once the guidelines change. PASMO is also currently working on transferring the processes of supervision and quality assurance audits to the MoH.

Provision of Tubal Ligation by Associate Clinicians/Clinical Officers in Uganda and Zambia

Gillian Eva, Technical Advisor for the Marie Stopes International (MSI) SIFPO2 project presented on two task sharing studies for voluntary tubal ligation services in Zambia and Uganda.

The Zambian government aims to increase access to voluntary permanent methods of family planning as a part of a broader method mix. To address limited method choice in rural areas and a heavy burden on doctors, an MSI study examined whether clinical officers (who have a diploma in clinical medicine with some semi-specialized training) could provide tubal ligation in Zambia. The study looked at the feasibility of operationalization as well as safety and acceptability. MSI trained four clinical officers (two MSI/Zambia and two MOH), who provided 195 tubal ligations through clinics and mobile outreach in the initial phase of the study, under supervision by a trained tubal ligation provider. Services were observed and clients were interviewed on day of procedure and three and seven days later. Initial analysis found that the procedures resulted in one major adverse event, nine moderate adverse events and 48 minor adverse events. The

Zambia study involved advocacy activities such as early engagement with key decision makers, and involvement of the MOH at every stage, as well as the development of a technical working group on family planning task sharing, and a data safety monitoring board.

MSI also ran a similar study design in Uganda in 2012 with four MSI Clinical Officers (COs) through mobile outreach, which yielded a 1.5% adverse event rate (compared to .87-24% by physicians in other settings). In this study, 99% of women reported having either a good or very good experience, and 97% would recommend the health service to a friend. While the results showed the feasibility of CO's providing tubal ligations, and the MoH is supportive of a change in policy, there are a number of outstanding barriers to be addressed first, including harmonization with the current policy framework, questions around cost-effectiveness, and issues of liability for COs providing the service.

A challenge in Uganda and Zambia was low client flow, which lead to the studies taking longer than planned, thus increasing the cost of the study and the time taken for the CO's to improve their skills. Ms. Eva noted that in all countries, acceptance of tubal ligation is low among many providers, policymakers and women, due to apprehensiveness around its permanence. Some health providers also experience opposition to task sharing from other cadres of health providers.

Task Sharing Map

Leigh Wynne, Senior Technical Officer for Research Utilization at FHI360, introduced a map that highlights task sharing research and research utilization activities to expand access to all methods of family planning around the world. The purpose of the map is to facilitate collaboration, information sharing, and advocacy. Prior to the meeting, a survey link was distributed for participants to respond with answers about where they were doing projects that involved family planning and task sharing. The map continues to be populated on the FP2020 site, and will be published soon.

A closer look at community-based provision of implants

Lois Schaefer, Senior Technical Advisor at the USAID Office of Population and Reproductive Health, moderated this session, which tackled issues related to community-based insertion and removal of implants.

Task Sharing of Implant Insertion to Community Health Workers: The Ethiopia Experience

Dr. Candace Lew, Senior Technical Advisor for Contraception at Pathfinder International, spoke on task sharing of implants in Ethiopia, where 84% of the population is rural. Prior to 2009, implants were available only at hospitals and health centers. In 2007, the MOH created a new, paid cadre of health workers, called health extension workers (HEWs), who, with a basic 10th grade education, attend a one-year training on a 16-element community health package. In 2009, a pilot was undertaken to add implant insertion to their delivery of services at the community level. During the Integrated Family Health Program pilot, 218 HEWs from four regions received a competency-based didactic and clinical training on implant insertion. As each health post was staffed by two HEWs, service provision of implant insertion was thus brought to the community level. Demand creation included work by volunteer community health workers, HEWs themselves, and mobile teams to villages.

During the scale-up phase, the project revised its regional management structures, improved training coordination, reinforced commodity security, and increased supportive supervision. By 2015, 9518 HEWs had been trained on Implanon insertion. Providers at health centers received implant removals training and removal kits. These providers offer removals at health centers, at health posts, through regular back up services, and, upon request by the woreda level, in areas without providing health posts or health centers. PSI's 2016 FPwatch study found that in the four largest regions of Ethiopia, 20% of all couple-years of protection, across all methods and cadres, come from implant insertions by HEW/health posts. This finding highlights the substantial impact of task sharing of implant insertions.

Dr. Lew described several lessons that were learned through this work: Task sharing can be an important strategy to increase access to implants at the community level, but to do this, commitment from all levels of the MOH is essential. In addition, competency-based trainings and follow-up with mentorship and supervision are critical to quality services with task sharing. Lastly, ensuring adequate implant removal services can be accomplished with multi-pronged strategies.

Task Sharing Policy Change and Implementation in Nigeria

Dr. Kayode Afolabi, the Head of Reproductive Health from the Federal Ministry of Health of Nigeria, presented Nigeria's experience changing policies to enable community-based provision of implants and IUDs.

Due in part to funding constraints, Nigeria faces a shortage and inequitable distribution of health workers, which limits access to voluntary family planning and other essential health services. Community-health extension workers (CHEWs) significantly outnumber nurses and midwives: the country has 36,737 CHEWs compared with 5,604 nurses and midwives. CHEWs have undergone a 36-month course in a training institution approved by the Federal Ministry of Health through the Community Health Practitioners Registration Board of Nigeria. The curriculum covers 90 hours of lectures and competency-based trainings.

Evidence showed that CHEWs can be trained in basic reproductive and maternal health services, including provision of several methods of family planning. Based on the WHO's recommendations to embrace task sharing in circumstances where it can be done safely, the Federal Ministry of Health developed a policy to enable CHEWs to add LARCs to their service offering. The policy development process included:

- Advocacy and consensus building among all stakeholders including professional regulatory bodies, state and non-state actors, pre-service institutions, service providers and others.
- Review of examples of task sharing in country as well as evidence from other countries with similar health systems.
- Engagement with stakeholders to develop a more comprehensive essential health services package.
- Approval of the policy at the National Council on Health meeting in Uyo, Akwa Ibom State in 2014.

Under the policy, CHEWs can provide:

- Family planning education and counseling in support of informed choice
- Promotion of dual protection
- Provide short-acting contraceptive methods including initiation and maintenance of injectables
- Insert and remove implants and copper IUDs
- Referrals for other methods and services.

All CHEWs must achieve competency-based accreditation before beginning to offer these voluntary family planning services. On an ongoing basis, quality is assured through supportive supervision with a feedback cycle. Each clinical trainer supervises five CHEWs. Exit interviews are also used to receive client feedback.

Steps to operationalize the task sharing policy included a review of the CHEWs' pre-service curriculum to incorporate nine-day training on LARC provision, ongoing in-country studies to validate that CHEWs can achieve competency and to document lessons learned, revision of policy documents, and revision of the CHEW training curriculum. The development of a national implementation framework and rollout plan is in progress.

Thus far, 334 CHEWs from nine states have received training in LARC provision. From the first quarter of 2015 to the first quarter of 2016, the number of implants provided nationally has more than doubled. The Rivers and Zamfara states have seen even greater increases, with implant insertions increasing 20-fold in Rivers and 10-fold in Zamfara.

Recommendations for future projects include the need for operations research to identify local implementation standards and processes; obtaining buy-in of all strata of government for ownership, funding and sustainability; developing operation and implementation plans; and coordination of partners to ensure implementation is standardized, supervised and monitored.

Marketplace of Tools and Resources for Task Sharing

During the lunch break, participants had the option to sit at a table with an expert and learn about the following tools for task sharing:

- Gillian Eva from MSI:
  - The task sharing impact model is a tool for high-level advocacy and policy change. The model looks at current contraceptive service provision and quantifies the benefits of different task sharing scenarios, exploring how the ratio of providers to clients could be improved, how the time of doctors could be freed up, and both cost effectiveness and health impact.
- Laura Reichenbach from Population Council:
  - The Research Planning Framework for Task Sharing FP Services was developed by the FP Task Sharing Technical Working Group to assist with the identification of research needs at the country level.
- Megan Christofield from Jhpiego:
  - The Implant Removals Taskforce, a subgroup of the LARC and PM Community of Practice, is working to develop tools to address the need for better access to removals.
- Bryan Shaw from PSI:
  - FPwatch is a multi-country research project that gathers contraceptive market data on FP method availability, service readiness, market share, and price across health facilities. The data can be used to advocate for task sharing policy change.
- Sara Stratton from Palladium:
  - The Health Policy Project used desk review and key informant interviews to produce a report on FP task sharing in West Africa.
- Erin Portillo from HC3:
  - Communication materials to help increase access to LARCs for youth include a video, discussion guide, and a series of adaptable posters and a brochure.
- Tore Laerdal from Laerdal Global Health:
  - Anatomical models, including the Mama-U model of a post-partum uterus, are available as provider training aids.

Small group discussions: Moving task sharing from research to practice

Group discussions provided a time to focus on key challenges of task sharing with respect to permanent methods, IUDs—including post-partum IUDs (PPIUDS)—and implant insertion and removal. In light of the morning plenary presentations, meeting attendees participated in the following three working group discussions:

- Group 1: Community-Based insertions and removals of implants by CHEWs facilitated by Moriam Jagun, Senior Family Planning/Reproductive Health Program Manager for Health Population and Nutrition Office for USAID in Nigeria
- Group 2: Task Sharing of IUDs, including PPIUDs within facilities facilitated by Trish MacDonald, Senior Technical Advisor in USAID's Office of Population and Reproductive Health

- **Group 3:** Task sharing of Permanent Methods facilitated by Kimberly Cole, Technical Advisor in USAID's Office of Population and Reproductive Health

The agenda called for three 30-minute rounds of repeated, concurrent working groups, allowing for meeting attendees to converse about all topic areas, and consider three key questions:

- What are countries or settings with a need to introduce this type of task sharing?
- What will it take to make this type of task sharing a standard practice?
- What are priority next steps for action?

The main take away points from the small group discussions are as follows:

Community-based insertion and removals of implants by community health extension workers

This group discussed how **human resource shortages** in rural areas and **limited access to wide mix of contraceptive products** heighten the need for task sharing of implant provision within the context of informed choice.

Participants shared ideas for how to **improve research** on task sharing. They highlighted the need for the conditions of service delivery during research to mirror, as closely as possible, the conditions that would realistically be in place during scale up. Participants described this as "having the end in mind right from the start." They also underscored the need to include outcome measures beyond safety and quality, since decision-makers also need cost analysis, data on continuation of use, effectiveness, and other information before bringing task sharing to scale.

Participants also recommended efforts to build consensus and **obtain buy-in** and political will from local governments and stakeholders, including non-traditional stakeholders, throughout the research process.

The group highlighted that **policy change is necessary but not sufficient on its own** to enable successful community-based provision of implants. The group highlighted the importance of conducting a whole health systems analysis, and ensuring that systems are ready for task sharing, including in relation to a secure supply of commodities. As Lois Schaefer of USAID wrote in an article on task sharing of implant provision:

> "Demonstrating that a health service, such as providing contraceptive implants, can be safely task shared to less highly trained workers is crucial but is only one step toward effective implementation at scale. Providers need dedicated time, enough clients, supplies, supervision, and other system support, allowing them to maintain their competency, confidence, and productivity."[1]

Questions on ensuring **continuity of care** arose, particularly in relation to implant removals, which require a higher level of skill than insertions. Ideas to address this concern included regular mobile outreach by supervisors to offer removals, oversee the work of community health extension workers, and provide on-the-job training and supportive feedback to help community health extension workers improve their skills. The case study from Ethiopia presented in the morning session provided one example of how to approach the challenge of ensuring access to removals at the community level.

[1] Schaefer L. Task sharing implant insertion by community health workers: not just can it work, but how might it work practically and with impact in the real world. Glob Health Sci Pract. 2015;3(3):327-329.

To further support sustainable scale-up in settings where community-based provision of implants is working well, participants suggested incorporating this training into the **pre-service curriculum** for community health extension workers.

Task sharing of IUDs, including PPIUDs, within facilities

This group discussed considerations and recommendations at multiple levels—including clients, providers, facilities, and systems—as they relate to task sharing of IUD insertions and removals.

Participants underscored the need for sufficient and sustained client flow in order for providers to maintain skills. In a setting where demand for IUDs is very low, task sharing of IUD provision may not be needed, cost-effective, or safe. On the other hand, the group hypothesized that task sharing could potentially increase demand for IUDs in two ways: a) cadres newly offering IUD provision could potentially charge lower user fees, thereby making IUDs more affordable, and attractive, to women and girls, and b) cadres newly offering IUD provision may be more motivated than others to offer the service and thus may take the time to speak with clients about the benefits of IUDs.

Participants offered suggestions to generate demand at the **client level**:

- Clients need to frequently hear messages about the positive aspects of the IUD, and to also have their concerns addressed and their questions answered, in order to have the knowledge, awareness, and interest to choose an IUD. Satisfied users, including providers who use an IUD, are often perceived as more trustworthy, and can speak openly and honestly about the method, and how they feel when using it. Word of mouth about positive experiences with services, and use of the method, can help increase demand. Advertising and marketing approaches also appeal to a variety of lifestyles when promoting the IUD.
- Counseling should be improved at all levels. If PPIUD providers are too busy to offer high quality counseling, then counseling could be delegated and shared with other cadres. In India, a new cadre was created solely to deliver postpartum FP counseling in facilities with very high volumes of deliveries.
- To demystify PPIUDs, providers could use a uterus model like the Mama-U during counseling.

The group described **"task sharing by force"** as situations where providers lack the time to keep up with demand for the service. In those cases, implementers and policymakers consider task sharing to increase the number of providers able to offer the service in order to meet existing demand. In contrast, **"task sharing by choice"** is a proactive strategy to make a service like IUD provision more available while also generating demand for it in new ways.

The group recommended research to explore the characteristics, including gender, of **providers whom women trust** to insert IUDs. Given that IUD provision puts clients in a physically vulnerable and exposed position, clients in some cultural contexts may prefer to receive the method from female providers. The group posited that if interval IUD provision is a task done by predominantly male cadres, sharing the task with a predominantly female cadre may serve to generate more demand. Participants clarified that provider gender is less likely to be an issue for postpartum IUDs if male providers perform deliveries.

Also at the **provider level**, the group recommended:

- Select cadres who perform tasks, like deliveries, that fit easily with IUD insertions. In many settings, midwives and nurses are not yet authorized to offer IUDs, or have not been trained to do so. These cadres are often well-suited to add IUD insertions into their scope.

- Select only those providers who are motivated to offer IUDs. Too often programs have failed to include IUDs among the methods truly available to clients because of provider bias.
- Make IUD and PPIUD insertions easier for providers to perform. This could include training and equipping providers to use the dedicated PPIUD inserter, a new technology designed to make PPIUD insertions simpler and more intuitive. Saving Lives at Birth invested in the PPIUD inserter and other new insertion technologies that are under development. Read more about technologies to streamline IUD insertions in the report from the LARC/PM CoP's July 13 meeting.

At the **facility level**, the group noted the need to:

- Select facilities that see high enough volumes of current IUD clients or deliveries that providers are likely to be able to maintain proficiency in IUD or PPIUD provision.
- Ensure that facilities have the necessary equipment, consumable supplies, and conditions (e.g., privacy, lighting, sanitation) in the right setting/rooms to allow for high quality IUD or PPIUD insertion.

At the **level of health systems**, task sharing policies are often in place but not operationalized. Participants recommended landscaping of markets and systems to identify the settings and sites to prioritize for IUD task sharing. They also noted that it's important to have the support of key stakeholders and influencers to ensure that quality IUD and PPIUD services are available.

Task sharing of permanent methods

The group that focused on task sharing of PMs discussed how the **differences between tubal ligation (TL) and vasectomies** create the need for separate conversations about task sharing of each PM. The literature has more studies and documentation of vasectomy task sharing than TL task sharing, although demand remains very low for vasectomy.

Participants raised several **barriers and challenges** related to supply, demand, and the enabling environment, and proposed **solutions** to address them:

- Since safety is more of a concern with PMs that other contraceptive methods, there is a need to approach task sharing of PMs cautiously. In addition, IUD use is increasing and the method can be used for 12 years, making some stakeholders question whether task sharing of PMs is a good investment. Participants suggested:
    - Conduct a **literature review** to document experiences, potentially revitalize enthusiasm among donors, and support advocacy. Although a number of success stories have been documented in the private sector, attention is needed to document PM task sharing in the public sector.
    - Develop a **decision-making tool** to aid analysis of when to consider task sharing (e.g., high demand to limit, sufficient client load for providers to maintain skills). It could also enable comparisons between task sharing, mobile outreach, and other service delivery models in a given context. Furthermore, the tool could also help implementers identify monitoring and evaluation needs.

- Due to the preparation required and the time the procedure takes, some providers hold bias against providing PMs. To help address this bias, **much of the preparation for and assistance during the procedure can be task shifted** even if the procedure itself is not. Participants also suggested involving other cadres in counseling.

- Given low demand for PMs in many settings, the group suggested:
    - **Social and behavioral change communication** (SBCC) could be improved by talking about PMs in a way that overcomes fear of the procedure and emphasizes freedom.
    - To **engage men** as users, implementers need to go where men are and talk with them about the health timing and spacing of pregnancy and the contraceptive options available, including vasectomy.
    - Additional research is needed on the total cost of PMs to the client (travel, consumables, recovery, opportunity cost of time away from work) compared to other methods. This would allow implementers and advocates to support efforts to **offset these costs** while respecting the principles of informed choice.

- Participants saw a need to improve the **quality of counseling** on PMs and suggested using videos, such as those used in training (e.g., Jhpiego and MCSP's tubal ligation training video) to counsel clients.

- The group noted that **abdominal surgeons** could be trained to offer tubal ligation, since they have relevant skills and knowledge.

- Participants noted that preservice training is often theoretical, with few or no opportunities to practice skills. The group highlighted the need for **practical training** as well.

Closing Remarks

Closing remarks were delivered by Ann Hirschey, the Chief of the Service Delivery Improvement Division in USAID's Office of Population and Reproductive Health, alongside Monique Burckhart of PSI and Trish MacDonald of USAID.

These speakers jointly closed the day by highlighting the need to continue documenting and sharing task sharing experiences to inform the next revision of the WHO guidelines as well as local decisions about how to approach and improve task sharing in different contexts. They reminded participants that, although it can be challenging to advocate for policy change, such upstream changes are a crucial element needed for success at scale.

The speakers encouraged participants to continue their efforts to move task sharing research from pilot to scale in settings where it is effective and adds value.

Attendees

Kayode Afolabi	Nigeria Federal Ministry of Health
Laila Akhlaghi	JSI
Kristely Bastien	PSI
Bruno Benavides	HRH2030
Monique Burckhart	PSI
Ariella Camera	USAID
Ben Cappiello	Bioceptive
Fabio Castano	MSH
Elaine Charurat	Jhpiego
Mervyn Christian	Johns Hopkins Bloomberg School of Public Health
Megan Christofield	Jhpiego
Kimberly Cole	USAID
Carmela Cordero	EngenderHealth
Elizabeth Creel	JSI
Peggy Dadamo	USAID
Gillian Eva	MSI
Mario Festin	WHO
Bamikale Feyisetan	E2A
Danielle Garfinkel	PSI
Elizabeth Gay	Population Reference Bureau
Brinda Gokul	World Bank
Carlos Leonel Gomez	PASMO
Dr. Leo Han	OHSU
Sarah Harlan	JHU/CCP – K4Health
Mark Hathaway	Jhpiego
Liz Hawryluk	PSI
Ann Hirschey	USAID
Laura Hurley	IntraHealth
Shahira Hussein	USAID
Ashley Jackson	PSI
Moriam Jagun	USAID Nigeria
Sabrina Karklins	Johns Hopkins Bloomberg School of Public Health
Robin Keeley	Population Council
Eckhard Kleinau	HRH2030, University Research Co.
Maggie Kohn	Merck
Shuchi Kurana	Bioceptive
Maryjane Lacoste	Bill & Melinda Gates Foundation
Tore Laerdal	Laerdal Global Health
Candace Lew	Pathfinder
Erika Martin	USAID
Trish MacDonald	USAID
Erin McGinn	Palladium

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